Vermont Dual Eligibles Demonstration
Model of Care

March, 2013

CONTEXTUAL OVERVIEW

Vermont's proposed Dual Eligible Demonstration is designed to achieve seamless integrated care, better outcomes, and improved quality of life for dual eligible individuals throughout the entire state of Vermont. To achieve this, the Vermont Agency of Human Services (AHS) will utilize the Department of Vermont Health Access (DVHA) as the single Health Plan for this Demonstration. DVHA operates using a public Managed Care model in accordance with 42 CFR §438, under authority of the Global Commitment to Health 1115 Medicaid Demonstration and Vermont state statute at 33 V.S.A. § 1901.

Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid managed care contract requirements. As such, since the inception of the Global Commitment Demonstration, DVHA has successfully modified operations to meet managed care program requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance and quality improvement. This is evidenced by a compliance score of 100 percent in the most recent review by the External Quality Review Organization contracted to evaluate DVHA's processes, documentation, and performance in complying with the federal Medicaid managed care regulations and the associated AHS IGA (contract) requirements.

DVHA has a strong statewide network of providers that are enrolled in Medicaid and Medicare that will comprise the network for the Dual Eligible Demonstration. This includes all hospitals, all skilled nursing facilities, all federally-qualified health centers, and almost every primary care provider and specialist in the state. It also includes a robust system of home and community-based providers in each geographic area of the state, including Designated Agencies for Mental Health Services, Designated Agencies and Specialized Agencies for Developmental Services, Substance Abuse Treatment Providers, Home Health Agencies, Area Agencies on Aging, Adult Day Centers, Traumatic Brain Injury Providers, Residential Care Homes, and Assistive Living Providers.

A centerpiece of Vermont's primary and acute care system is the Blueprint for Health, which is a multi-payer Advanced Primary Care Practice (APCP) program mandated to be statewide prior to the Demonstration start date. The Blueprint for Health program includes monthly payments to providers for meeting nationally-established performance measures, and multi-disciplinary Community Health Teams (often co-located) to support APCP patients when more follow-up support is needed to augment the APCP services, including shared health records between the APCP and Community Health Teams (CHTs).

Vermont's Model of Care proposes to introduce seven new Core Care Model elements into Vermont's service delivery system for individuals enrolled in this Demonstration:

1) *Enhanced care coordination with a single point of contact.* Each dually eligible individual will have a single point of contact to ensure coordination and integration of care across primary, acute, mental health, substance abuse, developmental, and long term care supports and services.
2) *Active involvement with a Blueprint medical/health home and a Blueprint Community Health Team (CHT).* Each individual will have an identified health home, preferably with a Blueprint advanced primary care practice (APCP), which includes access to a Blueprint CHT when needed. The Blueprint program is a population-based public health approach to prevention and evidence-based programs for primary and acute health care needs.

3) *Individual assessments resulting in comprehensive person-directed care plans across primary, acute, mental health, substance abuse, developmental, and long term care supports and services.* The Comprehensive Care Plan will reflect all the individual's needs and strengths to define specific service and treatment goals and objectives, and drive actions of the beneficiary's Inter-disciplinary Care Team.
4) *Support during care transitions.* Assisting individuals during their care transitions (e.g. between providers and/or settings) will enhance opportunities to improve continuity of care, sustain people at home and in the community, avoid unnecessary re-admissions, and assure that key supports are not lost during transitions.
5) *Payment reform connecting provider payment with performance measures related to changes in utilization and quality.* Payment incentives will be used to help providers meet performance and outcome measures, and decrease the tendency for cost-shifting across providers and services.
6) *Improved sharing of health records, assessments, and information.* In support of broad health care reform efforts, Vermont is actively working to improve statewide HIT/HIE infrastructure for both consumers and providers through a complex set of integrated activities led by the DVHA Health Care Reform Division. This includes the development of a statewide data-sharing infrastructure being created by Vermont Information Technology Leaders; supporting implementation of a statewide network of Electronic Health Records (EHRs); developing the connectivity to enable individuals and their chosen medical and support providers to access this information on-line; and incorporating federal and state privacy components.
7) *A single integrated pharmacy benefit plan.* The new plan will adhere to both Medicaid and Part D requirements, including a new Medication Therapy Management (MTM) program. Providing a single pharmacy benefit plan is expected to improve medication adherence and effectiveness, lower administrative costs for providers, and positively impact utilization of high-cost services such as emergency and inpatient visits.

For Demonstration beneficiaries that have needs beyond those provided by their primary care medical home, DVHA will contract with existing qualified providers to serve as Integrated Care Providers (ICP). ICPs will provide Enhanced Care Coordinators who will be responsible for working with the individual to assess their needs and provide a single point of contact to coordinate comprehensive and ongoing care across all providers in the health care system, including medical providers; designated agencies and other long term care providers; other social services providers; and peer support organizations. A provider or provider network that serves as an ICP will receive a payment from the state for providing enhanced care coordination. The same providers could also opt to be Integrated Care Providers-Plus (ICP-Plus) under which they will receive a capitation payment for a bundled array of services, in addition to providing enhanced care coordination. This new ICP/ICP-Plus structure will improve beneficiaries' experience through a person-directed individual assessment and care plan, with one point of contact responsible for ensuring that all of their needs are met.

INTRODUCTION

The Vermont system of care is robust, value-driven, and operates within the context of a history of state health and long term care reform efforts. However, from an individual's perspective, the system is confusing and fragmented, especially for those with multiple needs. For example, each individual served by one or more specialized home and community-based providers has a case manager and care plan associated with the services provided by that provider. As a result, the individual may have to meet with different case managers to get needed services. They also may have different care plans that are not integrated across the individual's providers and frequently do not contain or even reference the individual's medical treatment plan. This fragmentation can result in frustration, potentially serious health consequences, and inefficient use of system resources (e.g. poly-pharmacy, unnecessary ER visits or hospitalizations, redundant or conflicting interventions or support systems). Vermont's Demonstration intends to address this fragmentation in care for dual eligible individuals.

The Vermont Model of Care is designed to assure that every individual has access to a single point of contact who is also responsible for providing person-centered care coordination across all primary, acute, mental health, substance abuse, developmental, and long term care supports and services; conducting a health risk assessment that informs the development of a comprehensive care plan, based on individual needs; and leading an interdisciplinary care team to develop and operationalize the care plan in support of and with the beneficiary. In addition, the modal includes a web-based registry to allow for sharing of health records, assessments, and information across necessary providers involved with a beneficiary's care. Each of these elements is described in more detail below, including case studies that portray how beneficiaries will experience the specific aspects of the Modal of Care.

CARE COORDINATION

As described in detail below, the locus of a beneficiary's single point of contact/care coordinator will either be their primary care provider or an Enhanced Care Coordinator employed by an ICP/ICP-Plus, depending on the level of beneficiary's needs. Prior to enrollment in the Demonstration, all individuals will select both an APCP/PCP and an ICP/ICP-Plus. As such, even those individuals with only primary and acute health needs will have an identified ICP/ICP-Plus and Enhanced Care Coordinator which they can access if they develop more complex needs. Care coordination triage protocols will be developed between the ACPC/PCP, Blueprint CHTs, and ICP / ICP-Plus Enhanced Care Coordinators to ensure a seamless system from the perspective of the individual.

DVHA will contract with a vendor to assist with risk stratification and data analytics to identify those in need of Enhanced Care Coordination. The vendor will continuously employ an acuity tool which uses evidence-based algorithms to risk stratify the beneficiary population by identifying the highest cost/highest risk (HC/HR) beneficiaries and those with needs spanning across multiple service domains. DVHA will then notify the ICPs/ICPs-Plus of their enrolled beneficiaries for whom they should provide Enhanced Care Coordination.

In addition, DVHA and ICPs/ICPs-Plus will identify beneficiaries in need of Enhanced Care Coordination from other sources including, but not limited to:

- Enrollment in a specialized Medicaid LTSS program such as Choices for Care, Community Rehabilitation and Treatment, Developmental Services, or Traumatic Brain Injury. Enrollment in these programs is based on combinations of diagnoses and clinical or functional acuity.
- Referrals from primary care physicians or other medical providers
- Referrals from a Blueprint Community Health Team
- Referrals from the Vermont Chronic Care Initiative (VCCI)
- Self-referrals

Care Coordination for Individuals with Non-complex Needs

If the dual eligible individual only has primary or acute health care needs, the single point of contact will be their Blueprint for Health ("Blueprint") Advanced Primary Care Practice (APCP) provider, or other primary care provider (PCP) health home for the few individuals who do not have access to an APCP; as of the end of APCPs are expected to be available. (As of the end of 2012, the Blueprint program included 102 APCPs which serve over 67% of the State's population; the number is expected to increase substantially in Calendar Year 2013.)

The Blueprint APCP program, funded by all major insurers in Vermont and Medicare, is the centerpiece of Vermont's primary and acute care system. As an extension to routine PCP services, the Blueprint is based on advanced primary care practices (APCPs) that serve as medical homes for the patients they serve, and that receive monthly multi-insurer payments for meeting nationally-established performance measures.

The APCP/PCP is responsible for their members' health care needs by providing primary care medical services, referral authorization for needed specialty and other covered medical services, and arranging 24-hour-a-day/seven days-a-week coverage. The PCP also is responsible for developing the individual's Care Plan which comprises their primary and acute health needs.

A core component of the Blueprint is the establishment and multi-payer funding of Community Health Teams (CHTs) - multidisciplinary, locally based teams that work closely with and often located in the APCP setting. The CHT effectively expands the capacity of the APCP practice by providing people with direct access to an enhanced range of services, and with closer and more individualized follow up.

The CHT partners with the physicians and other members of the healthcare delivery team to establish improved coordination of the medical services needed by patients. If indicated, the CHT may conduct a comprehensive assessment of the patient's health needs, including health status and behaviors, level of function, psychosocial situation, and available support systems to ensure development of an individualized, appropriate plan of care. Again, as warranted, the CHT may re-evaluate the patient Plan of Care and initiate appropriate modifications, by collaborating with physicians, patient / family, and other members of the healthcare delivery team.

APCP physicians can immediately refer a patient to its affiliated CHT on an as needed basis. The team members can assist patients and families with care coordination for medical and acute needs; short-term mental health and substance abuse counseling; health and wellness coaching; enhanced self-management and education; and facilitating transitions of care including coordinating linkages with targeted specialty services (e.g. specialty care, mental health, substance abuse treatment, social services, economic services and DE Demonstration Enhanced Care Coordination). The CHT also supports

patients and families to be actively involved in chronic disease self-management through health coaching and motivational interviewing techniques.

Each CHT is staffed by five fulltime-equivalent employees and serves a population of approximately 20,000. (The size of the core CHT in each community is scaled based on the population being served in the APCP, with a half time position added for every 2,000 patients). The CHT is led by a registered nurse, who performs clinical duties and supervises the team. The remaining composition of any particular community health team is determined locally, with input from area practices and hospitals, but teams typically include additional registered nurses, mental health and substance abuse counselors, social workers and dieticians.

Case Study of Blueprint Community Health Team:

Lana, a 65 year old woman, is eligible for Medicare and Medicaid but has been in good health and not used a lot of services. She does not really understand what services are covered by Medicare or Medicaid. She has a primary care provider she only sees once every year or so for preventive care and standard tests. She is glad for her good health because she has little savings and is worried about keeping up her mortgage payments now that she is living on Social Security and a very small retirement pension. She drives but recently has been experiencing short dizzy spells and blurred vision so she has been trying not to drive. Yesterday she collapsed at the local supermarket and was taken to the hospital by ambulance. Lana is examined by the emergency room staff, and diagnosed with hypertension. She is given medication and a hypertension fact sheet, and discharged with instructions to contact her primary care physician.

Lana sees her Primary Care Physician within 2 days, whose practice is now in the Blueprint APCP program. Her PCP conducts a thorough physical, and notes that Lana is borderline obese. Her PCP adjusts the medication provided at the emergency room to be more congruent with her status as overweight, explains hypertension and how to control it, and provides her with informational brochure, and schedules quarterly visits for evidenced-based care of hypertension. During the visit, Lana shares that she has a lot of anxiety about her finances and uses food as a stress reliever; her PCP refers her to the practice-affiliated Blueprint Community Health Team for education and support about over-eating and ways to control stress. That day, Lana meets with the CHT behavioral health specialist to talk about stress control techniques and meets with the CHT nutritionist two days later for information about how to eat healthy foods on a low income. Lana's progress is measured by her PCP at scheduled quarterly visits, and her Individual Care Plan is updated during each visit. The PCP also reminds Lana at each visit that she can access an Enhanced Care Coordinator if she finds that she needs to receive more in-depth services for her anxiety and/or would like assistance coordinating her care (see below).

Care Coordination and Clinical Care for Individuals with More Complex Needs

The single point of contact for dual eligible Individuals who need more intensive mental health, substance abuse, developmental, and long term services will be an identified Enhanced Care Coordinator within an Integrated Care Provider (ICP) or an Integrated Care Provider PLUS (ICP-Plus) organization. ICP and ICP-Plus organizations will be selected through a Request for Proposal (RFP) process to be implemented once a formal MOU between CMS and the State of Vermont is signed; however, potential ICP and ICP-Plus organizations include state-designated mental health, substance abuse, developmental, long term care, and specialized care coordination providers that currently exist in

each geographic area of the state. This will ensure that the enhanced care coordination for these individuals is provided by an organization with sensitivity to the complexity of community-based and long term care services and supports.

Unlike the current situation where care management occurs within each specialty provider only for the services provided by that provider, the Enhanced Care Coordinator will be the beneficiary's single point of contact across *all* their primary, acute, mental health, substance abuse, developmental, and long-term care service needs. In general the role of the Enhanced Care Coordinator is to be the single point of contact for individuals who are dually eligible for Medicare and Medicaid to ensure that they receive necessary medical, pharmaceutical and long-term care services and support in a member-centered and integrated manner to enhance their quality of care, health outcomes and well-being.

The Enhanced Care Coordinator will be responsible for creating an individual needs assessment used to develop a person-directed Comprehensive Individual Care Plan; for assuring that the individual receives the clinical, pharmaceutical and support services in the Plan; and for providing support for the individual as he/she transitions across providers and/or care settings. This includes ensuring that the individual is seen by their APCP/PCP when needed, and coordinating with their affiliated Blueprint CHT and their MTM pharmacist as appropriate. With the individual's permission, the APCP/PCP Treatment Plan and the MTM Medication-related Action Plan will be embedded in their ICP/ICP-Plus Comprehensive Care Plan, which will be updated and shared across providers as the individual's needs or situation change. Enhanced Care Coordinators will not be gate-keepers but rather will be responsible for integrating care and improving access to the full range of services needed by the individual at any point in time.

Following are detailed functions to be performed by each Enhanced Care Coordinator:

- *Maintain a Member-centric Approach*
  - Educate, empower and facilitate the beneficiary to exercise his or her rights and responsibilities.
  - Provide information and support to the beneficiary in making choices.
  - Involve the Beneficiary as an active team member and stress beneficiary-centered collaborative goal setting.
  - As appropriate, represent the beneficiary's point of view when the member is unable to participate in discussions.
  - Adhere to and respect all policies regarding beneficiary rights, anonymity, and confidentiality of all beneficiaries past and present

- *Conduct Individualized Assessment*
  - Conduct an annual assessment of the beneficiary's needs and strengths across primary, acute, medication, mental health, substance abuse, developmental, and long term care supports and services, using the DE Demonstration assessment tool.
  - Follow up, as needed, to ensure in-depth assessments are conducted for more specialized needs (e.g., severe and persistent mental illness, long-term care)
  - Update the assessment process when a significant change occurs in the beneficiary's medical or life situation.

- *Develop Comprehensive Individual Care Plan*
  - Based on the results of all assessments and the beneficiary's needs and strengths, develop a Comprehensive Individual Care Plan with the beneficiary and other relevant team members that

defines specific service and treatment goals and objectives, proposed interventions, and measurable outcomes to be achieved
- Ensure the beneficiary's goals and preferences are identified, documented in the Care Plan and addressed.
- Identify the beneficiary's informal support systems/networks in relationship to his or her functional and safety needs, and include in Individual care plan as appropriate.
- Develop, monitor and review the effectiveness of the beneficiary's care plan with the beneficiary at least quarterly, and implement modifications as needed in collaboration with the beneficiary and other providers as appropriate.

➢ *Support the Beneficiary's Care Team and Care Coordination*
- Establish and maintain a routine working relationship with the beneficiary's primary care provider (PCP), with the beneficiary's Blueprint Community Health Team member(s), and with the beneficiary's MTM pharmacist as appropriate.
- Develop Interdisciplinary Care Team (ICT) for each beneficiary based on needs identified in the Individual Care Plan, and including the beneficiary's PCP.
- Establish a set of guidelines or care responsibilities for the beneficiary's entire team and distribute these responsibilities to all team members.
- Report new information to ICT, beneficiary and other appropriate providers as needed.
- Provide links/coordination/integration with care providers across settings.
- Make referrals and support beneficiary to access appointments and services, when appropriate.

➢ *Provide Routine Individual Support to Beneficiary*
- Assist beneficiary to access services and supports identified in the Individual Care Plan.
- Assist beneficiary to access public benefits, as needed.
- Assist the beneficiary in identifying and addressing quality of life issues.
  - Assure that the beneficiary has the supports necessary to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active.
  - Provide education to the beneficiary and family/other supports regarding identified health and social needs.

➢ *Support Beneficiary during Transitions in Care and Settings*
- Initiate contact with the facility case manager /discharge planner to facilitate transition in care and follow up, including receipt of discharge record
- Make an in-person visit to the member to facilitate transition in care assessment and appropriate follow up.
- Work with discharge planners to assure PCP/specialty visit is scheduled within 7 days of discharge, or more quickly if clinically indicated
- Coordinate linkages and follow-up with targeted services
- Provide beneficiary with support and relevant information specific to the beneficiary's condition; and
- Change the Individual Care Plan to reflect any new needs
- Communicate changes in Individual Care Plan with care team

➢ *Support Beneficiary to Self-manage Some or All Services*
- Provide beneficiary with information about the self-management program, and answer questions to help the beneficiary's decision-making regarding participation
- Support the beneficiary regarding self-management on an as needed basis as requested by the beneficiary

- *Other Duties*
  - Participate in weekly clinical staff/peer review meetings.
  - Demonstrate active involvement in supervision as evidenced by participation, initiative, and effort.
  - Adhere to all quality, preferred practice, and ethical standards as outlined in the Agency and DVHA DE Demonstration policies and procedures.
  - Meet all documentation and reporting requirements in a timely and accurate manner.
  - Record and documents services by following established policies and procedures of the Agency and the DE Demonstration.
  - Perform administrative duties, including writing monthly notes, treatment plans, clinical notes, and documentation of time for billing, MIS, outcomes, and payroll purposes.
  - Participate in and/or coordinates meetings, committees, and special projects as assigned.

Case Study of Enhanced Care Coordination:

Peter is 50. He and his wife rent an apartment and share a car. They both work and take turns driving each other to work. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He sees a mental health counselor and receives medication management by a psychiatrist at his local state-designated mental health agency. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy.

Under the new Vermont DE Demonstration, Peter's state-designated mental health agency is also his Integrated Care Provider (ICP). His ICP Enhanced Care Coordinator works with Peter to develop his Comprehensive Individual Plan and is Peter's single point of contact for coordinating his care and ensuring that all his care and treatment planning is integrated.

Peter's ICP Enhanced Care Coordinator finds a PCP that is taking new patients and assists him to get to the appointment. The PCP, who is part of a Blueprint Advanced Primary Care Practice, conducts a thorough physical and discovers Peter has diabetes, which has compromised his immune system and is causing the repeated pneumonia. The PCP prescribes an antibiotic for the pneumonia, and schedules routine visits for evidenced-based diabetes care, including blood work and foot exams. The PCP gives Peter some information about diabetes and how to control it, but also suggests that Peter could access the practice-affiliated Blueprint Community Health Team (CHT) if he would like additional information and support regarding managing his diabetes. Peter agrees, and the PCPs office sets up appointments for that afternoon. Peter meets with the CHT Nurse who further explains diabetes symptoms and management, and with the CHT Nutritionist who provides information about nutrition related to diabetes.

In the meantime, Peter's ICP Enhanced Care Coordinator has notified the PCPs office of her role (providing a signed agreement from Peter to release information to her on his behalf). Information-sharing tools and protocols have already been established (prior to implementation of the Vermont DE Demonstration) between the APCPs and ICPs in the region. As such, Peter's diagnosis of diabetes is entered into his Individual Care Plan.

With Peter's permission, Peter's ICP Enhanced Care Coordinator arranges for Peter and his mental health counselor to talk with the CHT staff regarding how to integrate diabetes management with the management of his depression. In addition, Peter's pharmacist works with him to develop a medication-related action plan (MAP) when he goes to fill his new prescriptions, since he is now taking medications for multiple diagnoses. Again, utilizing pre-established information-sharing protocols, the MAP is relayed to Peter's PCP and Enhanced Care Coordinator.

Peter and his Enhanced Care Coordinator then meet to update his Individual Treatment Plan to reflect the new goals and action steps related to his diabetes, and the revised Plan is shared with all the members of his care team.

Vermont Chronic Care Initiative (VCCI) as Alternative to ICP Enhanced Care Coordination

As previously noted, DVHA will contract with ICP and ICP-PLUS organizations for Enhanced Care Coordination, identified through a Request for Proposal (RFP) process before Demonstration implementation. The intent is to ensure that all dual eligible enrollees have close geographic access to an ICP and/or ICP-PLUS organization. However, if an adequate number or distribution of ICP or ICP-PLUS organizations is not identified though the RFP process, DVHA may elect to utilize its Vermont Chronic Care Initiative (VCCI) program to provide the enhanced care coordination for enrollees who do not have access to an ICP or ICP-PLUS in their geographic region.

Since 2007, the Department of Vermont Health Access (DVHA) Chronic Care Initiative (VCCI) has provided statewide care coordination, case management, and health coaching services for the highest cost, highest risk, and medically and socioeconomically complex Medicaid beneficiaries. The goals of VCCI care coordination and case management service is to assure individuals have a medical home, are accessing appropriate health services, receive evidence based care and have the skills and confidence to more effectively self-manage their own health.

Using a holistic approach and motivational interviewing skills, the VCCI care coordinators, which include RN case managers and social workers, work with the beneficiary to facilitate and assure an effective plan of care that supports health improvement through appropriate service utilization (medical home, prescription access, transportation to medical appointments, etc.). The VCCI care coordinators use approved assessment/screening tools to identify service needs as well as gaps in care, establish a priority based plan of care in partnership with the primary care provider and patient and implements the plan of care based on evidence based standards, program goals/metrics and Medicaid rules,

VCCI care coordinators are functional members of the Blueprint Community Health Teams (CHTs) to assist the team with unique needs of Medicaid beneficiaries that have complex needs. For example, in addition to supporting the CHT and primary care provider in achieving the clinical plan of care, the VCCI care coordinators facilitate effective communication and coordination among service providers, and work to remove barriers to beneficiary success through coordination with community support services.

Currently, VCCI does not provide support for dual eligible beneficiaries or for beneficiaries enrolled in Vermont's specialized programs for mental illness, substance abuse, developmental disabilities, traumatic brain injury or Choices for Care long term care programs. As such, VCCI primarily focuses on beneficiaries' medical needs. If DVHA utilizes VCCI to provide Enhanced Care Coordination for the DE

Demonstration, new VCCI staff will be hired to perform the enhanced care coordination function across all needs for dual eligible enrollees in the Demonstration.

Case Study for VCCI Care Coordination:

Joe, who is 52, is ready for discharge following a 3 day inpatient stay for Diabetic ketoacidosis (DKA). His discharge orders include an adjustment in his insulin and follow up with his PCP. However, this is Joe's 2nd inpatient stay in less than 4 months and he also has utilized the Emergency Department for hyperglycemia 4 times in the past 2 months. The hospital discharge planner considers a referral to the VCCI nurse case manager who she knows can provide intensive short term case management and is able to visit Joe in his home. She speaks to Joe about this referral and Joe agrees.

Joe and the VCCI nurse care coordinator meet for an initial visit with the goal of assessing Joe's readiness to improve his self-management and to assess barriers to self-care. At the end of the visit, it is determined that:

- *Joe is not always able to pick up his insulin and metformin on time as he does not have a car. At times, he can go a week or more without his prescriptions.*
- *When he does have his prescriptions, Joe forgets to take them as his memory is not what it used to be.*
- *Joe responds positively to the 2 initial depression screening questions. The VCCI nurse care coordinator further assesses his depression status and finds that Joe is moderately depressed.*
- *Joe is tired of going to the hospital and worries about his cat when he is not home for days at a time.*

Upon hearing from Joe that he is ready to work with VCCI with the goal of improving his diabetes so he does not have to go to the hospital, the VCCI nurse care coordinator and Joe develop his Diabetes Action Plan:

- *Joe will call his Medicaid transportation vendor and set up a ride to pick up his insulin, metformin and other medications.*
- *Joe will set an alarm on his cell phone as a reminder to take his medications.*
- *Joe will speak to his PCP at his 2 week follow up appointment about his depression.*

The VCCI nurse care coordinator has outreached to the nurse care coordinator at Joe's medical home and has provided an initial update re: initial assessment, barriers and depression screening results so that Joe's PCP has this information when he sees Joe at his follow up appointment.

Ongoing visits from the VCCI nurse care coordinator for further assessment and monitoring of his progress with his plan of care occur over the next 4 months. Outcomes include:

- *Joe can use his Medicaid transportation benefit to obtain rides to his pharmacy to pick up his prescription on time. Joe also has enrolled in the automated refill process at his local pharmacy so that he does not have to call for refills, but instead receives a call from the pharmacy notifying him that his prescriptions are ready.*
- *Joe will access medication management services through home health nursing who will assist Joe in setting up his medication box and help monitor his adherence.*
- *Joe has seen the Blueprint CHT behavioral health specialist that sits at his PCP and sets up weekly sessions for ongoing counseling.*

- *His A1c has dropped from 13.5 to 11.1 and he has had only 1 Emergency Department trip in the past 4 months.*

Beneficiary Self-Management

Self-management under the DE Demonstration will be modeled after the existing Flexible Choices self-management option within the Vermont Choices for Care Program. The Flexible Choices program provides beneficiaries an option to have self-or-surrogate-managed flexible use of the resources associated with their home and community-based services in their Individual Care Plan. These services include, but are not limited to, personal care; adult day services; other professional services; goods (i.e., other items that do not fit in any other category): and a fiscal intermediary services organization to help manage payroll for beneficiary-hired workers and other costs associated with care at home.

Beneficiaries have monthly cash-value allowance with which to purchase their care and services. The beneficiary uses this budget to develop their own package of services tailored to their needs. Once established, the enrollee can then modify the use of these resources at any given time to meet their needs, as long as the uses meet the program guidelines. To be eligible for the Flexible Choices option, an individual must complete a Self-Screening Tool to indicate a capacity to handle the responsibilities of the option.

One of the primary responsibilities of an Enhanced Care Coordinator will be to provide beneficiaries with information about the self-management option. If interested in enrolling, the Enhanced Care Coordinator is responsible for assisting the beneficiary to complete the necessary forms. Once enrolled in the program, the Enhanced Care Coordinator is still available, if requested, to assist and support the beneficiary in planning their care and developing and managing their budget. In addition, peers who are already enrolled in the option will be available as resources and supports for those exploring the option and those already enrolled.

Case Study for Beneficairy Self-Management :

Alice is enrolled in the Dual Eligibles Demonstration which includes the Flexible Choices (self-management) option. She has a physical disability which limits her ability to attend to her personal care needs, as well as do day-to-day activities such as home and yard maintenance, without assistance. Before becoming a beneficiary in the DE Demonstration, Alice did not know about the Flexible Choices program. However, her new Enhanced Care Coordinator informed her about the program when they first met, including providing Alice with written material about the program so she could take it home and consider whether it was a good fit for her. They agreed that Alice would call the Enhanced Care Coordinator if she wanted to enroll in Flexible Choices or to talk about it more, or Alice could wait until their next routine visit. Her Enhanced Care Coordinator also gave Alice the names of two other beneficiaries enrolled in the program with needs similar to Alice who had agreed to serve as contacts for people who wanted additional information. After Alice read the materials and talked with one of the people already enrolled in the program, she became very excited and called her Enhanced Care Coordinator to discuss a few of her concerns. Once Alice was reassured that her Enhanced Care Coordinator would still serve as her single point of contact and be responsible for coordinating her care across all acute and long-term needs when Alice requested it, she met with her Enhanced Care Coordinator to complete the enrollment from. Within a week, Alice was enrolled in the program.

The primary services and supports in Alice's Individual Care Plan include routine physical exams by her PCP, personal care hours and individually identified flexible supports (i.e., items and activities related to Alice's disability that do not fit into any other category, such as yard and home maintenance). She has pretty reliable personal care, but a few weeks ago her evening Personal Care Attendant (PCA) became ill. She was not able to find good backup coverage and spent a couple nights sleeping in her wheelchair. As a result, she developed a pressure sore and an infection. She called her Enhanced Care Coordinator who contacted Alice's PCP to get a referral to a skin specialist. Her Enhanced Care Coordinator assisted her to get to the Specialist appointment, who cleaned the ulcer site in the office; prescribed oral antibiotics and extended bed rest (off of pressure sore), gradually decreasing over 4 weeks; prescribed in-home wound care by a nurse twice a week; prescribed a Physical Therapy (PT) home evaluation for pressure problems; and scheduled a follow-up appointment in two weeks.

Alice's Enhanced Care Coordinator then assisted Alice to coordinate her follow-up care by arranging for a Home-health nurse to do in-home wound care twice a week; arranging for the PT home evaluation of her bed, wheelchair, shower bench, etc. for pressure problems; and assisting her to obtain a new wheelchair cushion. She also worked with Alice to revise her Individual Care Plan to incorporate the limited-time need for more personal care hours while she was on bed rest and assited a Alice to find PCAs to fill the additional hours. They also developed a strategy to ensure that PCAs arrive as scheduled, and a pre-arranged emergency back-up plan in case a PCA does not arrive. The Enhanced Care Coordinator also ensured thatALice had the transportation supprts she needed to attend the follow-up appointments with skin specialist, since Alice could not sit up until the pressure sore was healed.

INTERDISCIPLINARY CARE TEAM

As noted above, a primary responsibility of Enhanced Care Coordinators will be to establish Interdisciplinary Care Teams (ICTs) for each beneficiary. ICTs will be comprised of providers from primary, acute, mental health, substance abuse, developmental, and long-term care services, but provider participation will change according to the specific needs of a given beneficiary at any given time, as defined in the beneficiary's Plan of Care. For example, an individual with a developmental disability who is losing his sheltered housing requires a different composition of providers than an elderly person needing follow-up medical care and long term services and supports upon discharge from a nursing facility. Similarly, as a beneficiary becomes stable after a transition, the members of the ICT will need to change to reflect a change in beneficiary needs.

The Enhanced Care Coordinator will be responsible for convening ICT meetings; for documenting all discussions, decisions, and action plans that result from the ICT meetings; and for distributing relevant materials to all ICT participants, other health care providers, and the beneficiary prior to and following the meetings, or at any other time that this type of communication must occur.

The ICT will meet quarterly, unless there is a change in the beneficiary's needs or goals. The ICT will review the beneficiary's Care Plan with the beneficiary and adjust it if change is agreed upon at the meeting. Team meetings will occur in person, with the option to attend by teleconference. Attendance by all ICT members is required. However, a beneficiary can approve that the meeting be held without one or more of the members, by indicating this to the Enhanced Care Coordinator either verbally or in writing, which will then be documented in the minutes of the ICT meeting.

The Enhanced Care Coordinator is responsible for ensuring that ICT members are notified of a change in the beneficiary's needs/goals, convene a Special ICT meeting (if appropriate) within 5 working days, and update the Care Plan as a result of the meeting. The Enhanced Care Coordinator also will be responsible for contacting by telephone any new provider involved with the beneficiary due to the change, sharing the beneficiary's Care Plan, and inviting them to the Special ICT meeting.

ITC members will work from an established set of standard operating principles, guidelines and care responsibilities, using the beneficiary's Individual Care Plan as their foundation.

Standard Operating Procedures (SOPs) for the ICT will include:

- The Enhanced Care Coordinator is always available to the beneficiary as a single point of contact regarding his/her Care Plan or service needs, and is the focal point for all ICT communications regarding service delivery and supports.
- The Enhanced Care Coordinator will be the "Lead" person on the ICT and will have established relationships with the beneficiary's primary care provider (PCP), the beneficiary's Blueprint Community Health Team if applicable, the beneficiary's MTM pharmacist if applicable, and other team members as appropriate.
- ICT membership is driven by the beneficiary's Care Plan.
- The beneficiary, or their designated representative, is always included as an equal participant.
- There must be equal participation and responsibility on the part of team members to ensure the beneficiary's needs and goals are met, with "shifting" responsibility determined by the nature of the problem to be solved.
- Scheduling ICT Meetings:
    - The Enhanced Care Coordinator will coordinate and schedule ICT meetings.
    - Routine ICT meetings will occur at least quarterly, and must be scheduled at least 2 weeks in advance, at a time agreeable to all team members.
    - Special ICT meetings, due to unplanned changes in the beneficiary's needs/goals, will be scheduled as timely as possible after the need is identified, but no later than 5 working days.
    - ICT members must immediately notify the Enhanced Care Coordinator if he/she cannot attend the ICT meeting. Every effort will be made to re-schedule the meeting when all required members can attend.
- Changes in Beneficiary Needs/Goal, Care Plan and ICT membership
    - The Enhanced Care Coordinator is responsible for ensuring that the beneficiary's Care Plan is updated due to a change in the beneficiary's needs or goals.
    - The Enhanced Care Coordinator will identify if new members need to be added to the beneficiary's ICT due to the changes in beneficiary needs/goals; the Enhanced Care Coordinator will:
        - Contact the new member(s) by telephone to explain the situation
        - Share the beneficiary's Care Plan with the new member(s)
        - Provide new team member's contact information to all ICT members, including the beneficiary.
    - If an ICT Member becomes aware of a change in the beneficiary's needs or goals, the member will contact the Enhanced Care Coordinator to initiate the above process.
    - Led by the Enhanced Care Coordinator, the team will provide links, coordination, and integration of services across settings and will facilitate referrals to appropriate providers and social service agencies.

  - The Enhanced Care Coordinator also will ensure that care is coordinated and integrated for individuals transitioning across providers and/or care settings by either working with the appropriate ICT member or directly initiating contact with facility case managers/discharge planners to facilitate transition in care and follow up, including receipt of discharge records.

- Working Principles for the ICT include:
  - Mutual respect for the expertise of all members of the team, including the beneficiary.
  - Knowledge and trust among all parties establishes quality working relationships.
  - Shared responsibility which leads to joint decision-making.
  - Communication that is not hierarchical, but rather multi-directional - facilitating sharing of information and knowledge.
  - Cooperation and coordination which promote the use of the skills of all team members, prevent duplication, and enhance productivity.
  - Provide links/coordination/integration with care providers across settings.
  - Emphasis by the team on "health care and public health" rather than the more narrow focus of "medical care". This broadens the roles and responsibilities of non-physician health care providers.
  - Optimism that this process is the most effective method to achieve quality care and improved outcomes.
  - Meet all documentation and reporting requirements in a timely and accurate manner.
  - Adhere to all quality, preferred practice, and ethical standards as outlined in the DVHA DE Demonstration policies and procedures.

Beneficiaries, or their designated representatives, will always be involved in the development of their Care Plans and invited to be included as an equal participant in the ICT. The Enhanced Care Coordinator, functioning as the beneficiary's single point of contact, will be the liaison between the beneficiary and the ICT and responsible for guaranteeing beneficiary involvement in the process. However, beneficiaries may access any ICT member at any time; if the contact is due to a change in the beneficiary's need or goals, the ICT member will notify the Enhanced Care Coordinator to initiate the process described above.

Each beneficiary's Care Plan will include their preferred method of communication with their Enhanced Care Coordinator for routine communications such as scheduling meetings (i.e., telephone, electronic mail, or written notification using postal mail). The Care plan also will include the beneficiaries' preferred method for participating in the ICT meetings (e.g., in person, by telephone or being informed of the results after the meeting). Beneficiaries also may designate someone to represent or support them at the meetings, in which case the Care Plan also will include this information for the designated representative. Using the identified mode of communication, and the beneficiary's preferred method of ICT participation, the Enhanced Care Coordinator will contact the beneficiary (and representative if appropriate) to schedule (or inform them of) the ICT meetings.

*** (Note: from this point forward in the document, the term beneficiary will also be meant to include the beneficiary's designated representative) ***

The beneficiary will be given educational and resource materials prior to the meetings. All materials will be developed using necessary accommodations to address any cognitive, functional or language barriers unique to the beneficiary. To encourage beneficiary involvement in the ICT meetings, the Enhanced Care

Coordinator will discuss these materials with the beneficiary in advance of the meeting and provide additional information as requested.

The following standards for beneficiary involvement will guide all activities by the Enhanced Care Coordinator and ICT members:

- Educate, empower and facilitate the Beneficiary to exercise his or her rights and responsibilities.
- Involve the Beneficiary as an active team member and stress beneficiary-centered collaborative goal setting.
- Provide information and support to the Beneficiary in making choices.
- Develop, monitor and review the Beneficiary's care plan with the Beneficiary.
- Ensure Beneficiary's goals and preferences are identified, documented in the care plan and addressed.
- Ensure all verbal and written communication with the beneficiary is presented in a manner that the Beneficiary can understand. Always ask questions of the Beneficiary to ensure that they understand it.
- Ensure that the Beneficiary has timely access to necessary services and supports
- Provide links/coordination/integration with care providers across settings.
- Provide education to the Beneficiaries and families regarding health and social needs.
- Identify the Beneficiary's informal support systems/networks in relationship to his or her functional and safety needs.
- Report information to team, Beneficiary and other appropriate heath care providers as needed.
- Assess and assist the Beneficiary in identifying and addressing quality of life issues.
- As appropriate, represent the Beneficiary's point of view when the member is unable to participate in decisions.

Case Study of an Interdisciplinary Care Team:

Ken has quadriplegia due to a spinal cord injury when he was 19. He needs personal care assistance for showering, getting dressed and transferring into his electric wheelchair in the morning and getting undressed and transferring into bed at night. He has environmental in his apartment and Occupational Therapy adaptations to enable him to prepare and eat meals. He has a Vocational Rehabilitation counselor who helped him find a job and an adapted van he purchased with assistance from a special Vocational Rehabilitation fund. He has limited lung capacity due to his spinal cord injury, so uses a Bi-Pap machine at night. He takes oral Baclofen to help control his leg spasms. Ken's Enhanced Care Coordinator is employed by the local Home Health Agency that has a contract with DVHA as an ICP.

The Care Plan developed by Ken and his Enhanced Care Coordinator includes Personal Care Attendants twice a day, routine annual visits with his PCP, annual maintenance check-ups for his wheelchair, quarterly prescription refills for his Baclofen, and quarterly meetings with his Vocational Rehabilitation Counselor.

The ICT members identified in Ken's Care Plan are his Enhanced Care Coordinator (who is the ICT lead), his Vocational Rehabilitation counselor who works for the State, his primary care physician (represented by the PCP's nurse care manager), and an Occupational Therapist employed by the Home Health Agency. The Care Plan also specifies that Ken and his ICT will meet every three months by phone conference just to check in. In the meantime, while Ken can contact anyone on his ICT directly at any time, he prefers to go through his Enhanced Care Coordinator when he has a question or wants to change anything in his

Care Plan, since he knows she will coordinate any subsequent actions and communications across his ICT that might need to occur.

Unfortunately, Ken developed pneumonia, which was diagnosed by his PCP, who is a member of Ken's ICT. Ken was given antibiotics and told he needed to be on bed rest for 2 weeks, especially since his lung capacity was already compromised by his spinal cord injury. He also was scheduled for a follow-up visit with the PCP in two weeks. The PCP nurse case manager contacted Ken's Enhanced Care Coordinator via telephone to inform her of his new condition, and they agreed that the PCP nurse case manager would input his new diagnosis and treatment plan into Ken's comprehensive Care Plan on the web-based registry.

The Enhanced Care Coordinator also contacted Ken directly to remind him that she was available to help with arranging any of his immediate needs. They briefly discussed the fact that Ken might need more in-home assistance with preparing and eating meals, and that he needed to notify his employer of the situation. At Ken's request, the Enhanced Care Coordinator contacted Ken's employer by telephone and worked with co-workers in her agency (which is a home health provider) to identify an in-home support worker who could meet Ken at his home that day to discuss his new temporary needs for assistance. They agreed that the Enhanced Care Coordinator also would convene a Special ICT meeting within 24 hours to discuss needed changes in his Care Plan during this event.

Ken and his Enhanced Care Coordinator discussed what team members he thought were important to attend the Special ICT meeting to be scheduled within 24 hours. Ken stated that he thought his Vocational Rehabilitation (VR) Counselor did not need to attend the meeting if she was not available. When the Enhanced Care Coordinator contacted the team members by phone to schedule the meeting, the VR Counselor indicated he would like to attend since there may be implications for Ken's employment if his pneumonia does not get resolved within the expected timeframe.

The Enhanced Care Coordinator contacted all of his ICT members by telephone and they scheduled an ICT meeting by teleconference for 9:00 am the following morning. Ken participated in the Special ICT meeting via telephone use the speakerphone function. At the meeting, they added the new temporary in-home assistant to his list of needs, and identified that the Coordinator would follow-though to ensure that staff were identified to assist him throughout his required bed rest. It also was suggested that Ken's OT team member should arrange for an in-home OT consultation within the next 24 hours to determine if any equipment or special accommodations would help him be more comfortable or functional while on bed rest. This was also included in his Care Plan with the OT member identified as the lead on this activity. Following the ICT SOPs, the OT member agreed to notify the Enhanced Care Coordinator of any identified needs and the actions taken, so they could be include in the Care Plan. In addition, during the ICT meeting Ken noted that since he is on prescribed bed rest, he cannot communicate via his preferred method of electronic mail. This was noted in the Care Plan, with an associated action that all correspondence with Ken would need to occur via telephone until he is no longer on bed rest.

Following the Special ICT meeting, the Enhanced Care Coordinator updated his Care Plan and notified all of his ICT members via the web-based registry notification system that the updated plan was available through the web-based registry. She also sent another communication the following day notifying them that the Care Plan had been updated to include home adaptations.

When Ken attended the scheduled follow-up visit with his PCP two weeks after his diagnosis of pneumonia, the PCP determined that Ken's pneumonia was resolved. The PCP nurse case manager, a

member of Ken's ICT, notified Ken's Enhanced Care Coordinator through the web-based registry notification system that Ken's pneumonia had been resolved. As prescribed in Ken's Care Plan, the PCP nurse practitioner also updated Ken's Care Plan in the web-based registry to reflect these changes regarding his medical situation.

The Enhanced Care Coordinator recognized that Ken was able to return to work, and may no longer need the additional supports he required while on bed rest. The Enhanced Care Coordinator contacted Ken by email (his preferred communication method) to discuss if he was okay with reverting to his original Care Plan prior to the diagnosis of pneumonia. Ken agreed. Following ICT Standard Operating Procedures, the Enhanced Care Coordinator made the changes to Ken's Care Plan and used the web-based registry notification system to notify all of Ken's ICT members of this new information. The Coordinator also contacted her home-health colleagues by telephone to notify them that the temporary in-home assistants were no longer needed.

HEALTH RISK ASSESSMENTS AND INDIVIDUALIZED CARE PLANS

Health Risk Assessments

Vermont has undergone a comprehensive health risk assessment review process including stakeholders and advocates to determine the appropriate Health Risk Assessment (HRA) to use in the Dual Eligible Demonstration. This stakeholder process included representatives of agencies that serve all four cohorts of individuals who are dually eligible for both Medicare and Medicaid and will participate in the demonstration:

1. Choices for Care 1115 Demonstration Long Term Care Medicaid eligible (CfC) – both elderly and disabled
2. Developmental Disabilities Program eligible beneficiaries (DS) under Global Commitment 1115 Demonstration (GC)
3. Community Rehabilitation & Treatment eligible beneficiaries (CRT) under GC. CRT program serves individuals who are severely and persistently mentally ill
4. All other individuals who are dually eligible for both Medicare and Medicaid, which is a combination of individuals considered "community well" as well as individuals whose clinical eligibility/acuity level does not qualify them for CfC, DS or CRT.

The Health Risk Assessment tool that DVHA and its contracted Integrated Care Providers (ICP) or Integrated Care Providers Plus (ICP-Plus) will use is the Independent Living Assessment (ILA) used currently in the Choices for Care 1115 LTC waiver assessment. The ILA is a comprehensive assessment of an individual's needs. The elements that are included in this tool include:

- Consumer Individual identification
- Emergency Contact information
- Legal representative information
- Demographic information
- General health related questions
- Functional need questions
- Emotional health questions
- Cognition questions

- Nutritional health checklist
- A review of a checklist of services and programs
- Self-neglect, abuse and exploitation screening
- Supportive assistance questions
- Living environment questions
- Health Assessment
    - Diagnosis
    - Conditions
    - Treatment
    - Pain Status
    - Skin Status
    - Elimination Status
- Functional assessment – to include both Activities of Daily Living and Instrumental Activities of Daily Living

The Enhanced Care Coordinator at the ICP/ ICP-Plus will conduct the ILA with each beneficiary that is assigned to their caseload. The Enhanced Care Coordinator also will ensure that the Health Assessment component of the ILA is connected and coordinated with any health care assessments conducted by the beneficiary's primary care provider.

In addition to completing the ILA, the individual will be asked to respond to a series of self-assessment questions listed below to help with both the assessment and care planning process, including:

1. How is your health or disability affecting your ability to do the things that matter to you?
2. Are there specific health priorities or disability related goals that you want to address?
3. What personal interests, goals or quality of life priorities should we know about that can help guide our work together? (with follow up regarding independence, social life, work or other interests or activities that need to be planned for, supported, tied to outcome planning)
4. Are there resources, services or supports that are necessary or that would be helpful to your during medical appointments or other meetings?

Additional, more specialized assessments will be completed on an as needed case by case basis. For example, if the ILA assessment indicates that the beneficiary may need long term care services available through the Choices for Care program, the Enhanced Care Coordinator will arrange for the beneficiary to receive the necessary assessments to determine the beneficiary's clinical and financial eligibility for those services. As another example, a mental health counselor may be asked to conduct an additional assessment based on the beneficiary's responses to the questions asked in the Emotional Health section of the assessment.

The goal will be to conduct initial health risk assessments within 90 days of enrollment. Recognizing that this may not be feasible, depending on the number of beneficiaries enrolled at each ICP/ICP-Plus, DVHA will use claims data to assist in helping ICP and ICP-Plus providers determine the prioritization for conducting the assessments.

All team members will have access to the assessment. The full initial assessment will be conducted face-to-face if the beneficiary is not known to the Enhanced Care Coordinator. In some instances the beneficiary will be known to the Enhanced Care Coordinator as they are currently working with them under either CfC, DS or CRT waiver programs. For these beneficiaries, the Enhanced Care Coordinator will import existing initial assessment information into the web-based registry care management system

and meet with the beneficiary to include additional information as needed.

Annual reassessments will be conducted by the Enhanced Care Coordinator in face-to-face meetings with each beneficiary within one year of the last assessment. Reassessments also will be conducted more frequently if a significant change occurs, such as an inpatient hospitalization or readmission, or change in medical, environmental or psychosocial condition. Prior to Demonstration implementation, DVHA will work with the ICPs/ICPs-Plus to develop protocols for ensuring prioritized, timely reassessments due to a significant change.

The assessments will be available on the web-based care management registry system, described in more detail below. The Enhanced Care Coordinator will review all the assessment information and will make sure that the beneficiary has opportunities to ask questions as well as discuss and describe personal preferences and assessment concerns. The beneficiary will be given the opportunity to receive an electronic summary via email or a written summary of the assessment in the mail. The Vermont Agency of Human Services has developed and implemented a comprehensive and flexible process for Consumer Information Privacy Standards, which also are followed by DVHA and it contracted providers. The comprehensive nature of this process allows for sharing of information to occur on an as needed basis to multiple providers, but also allows dually eligible beneficiaries to state whom they do or do not want to allow access to shared information.

Individualized Care Plans

The Care Plan for individuals who only have minimal medical needs and do not require Enhanced Care Coordination for more complex or long-term care needs will be developed by their Primary Care Physician and the beneficiary. For all other dual eligible beneficiaries, their individualized care plan will be developed by the Enhanced Care Coordinator and the beneficiary based on the beneficiary's needs as identified through the assessment process described above, as well as input from other members of the beneficiary's ICT. For example, when a care plan includes medical or mental health aspects, those sections of a care plan will be developed by medical and/or mental health clinicians and coordinated by the Enhanced Care Coordinator.

The Comprehensive Plan of Care elements will include, but not be limited to, demographic and other contact information (e.g., emergency contact, representative for attending ICT and other similar meetings; legal representation); results of all assessments; goals/objectives; services and supports; preferences for care; and other preferences (e.g., preferred mode of communication with the Enhanced Care Coordinator and ICT members).

The Care Plan for individuals who only have minimal medical needs and do not require Enhanced Care Coordination for more complex or long-term care needs will be reviewed at least annually by their Primary Care Physician (PCP) at an annual visit with the beneficiary. For all other dual eligible beneficiaries, their individualized care plan will be reviewed by the Enhanced Care Coordinator and the beneficiary, and other members of the beneficiary's ICT. The Enhanced Care Coordinator is always responsible to review the Care Plan with the beneficiary on a regular basis and to communicate with the beneficiary's PCP, members of the beneficiary's ICT and other key providers to understand the beneficiary's current status and progress towards implementing goals. The Care Plan is revised more frequently if a significant change in health status occurs. All Care Plans will always take into consideration beneficiary preferences and goals.

Care needs, including specialized services, required by a beneficiary are coordinated through their comprehensive Care Plan. The Enhanced Care Coordinator is responsible for ensuring that the Care Plan and any revisions are communicated to the ICT, including the PCP, and to other providers involved in the beneficiary's care. This communication occurs either directly through the web-based registry care management system, via secure email or facsimile, or via postal mail. The Enhanced Care Coordinator also is responsible for ensuring that the beneficiary receives hard copies of their Care Plan, either through secure email or via postal mail, based on the individual's preference.

Case Studies of Health Risk Assessment and Plan of Care

Case study # 1: Dual Eligible Beneficiary with Mental Illness Enrolled in the Community Rehabilitation and Treatment (CRT) Program

A 45 year old male is living in his own apartment with support from the community mental health agency through the CRT program, which includes quarterly visits with a psychiatrist for medication management, supportive employment services, and case management. He has diagnoses of schizophrenia, depression, and asthma. He occasionally stops taking his psychotropic medications. This has led to mental health crises several times in the past five years, including numerous visits to the hospital emergency room. He smokes more than one pack of cigarettes per day, has not seen a physician in several years, and cannot name his primary care physician.

Under the DE Demonstration model of care, his Enhanced Care Coordinator (his single point of contact) performs an assessment which includes input from the primary care provider at the Blueprint practice as well as the psychiatrist at the community mental health agency.

After the assessment, a Plan of Care is developed with input from the beneficiary, the PCP, and the psychiatrist. The Care Plan includes biweekly contact with a mental health counselor; monthly contact with a nurse practitioner; consultation from a Medication Treatment Management (MTM) pharmacist; development of an asthma management plan, including training in self-management; enrollment in a tobacco cessation program, including financial incentives for active participation; and biweekly in-home visits from a community support worker to assist with his asthma management and tobacco cessation, monitor his medication and mental status, and supports his nutrition and physical activity.

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In addition, the beneficiary is aware of the high and low point cycles of his own illness and is motivated to reduce these cycles with help from the PCP office, his Enhanced Care Coordinator and peer supports. The beneficiary agrees as part of the Care Plan to call the Enhanced Care Coordinator and/or the primary care office nurse when questions come up and or his anxiety and depression appears to be escalating. As a result, they work as a team together to stave off emergency room visits by making changes to medication rapidly as needed and/or access to mental health supports more qickly when anxiety and depression symptoms are escalating.

Seven months later, a reassessment is conducted by his Enhanced Care Coordinator due to heart problems the beneficiary was having, which resulted in an ER visit and a subsequent operation putting stints into the veins of the beneficiary's legs. As part of the reassessment process, her updated medical assessment information is obtained from her primary care provider. The Enhanced Care Coordinator works with the PCP and the beneficiary to follow up on all of the discharge plan requirements, including exercise, diet and medication changes. His ICT – which is comprised of his Enhanced Care Coordinator, the nurse at the PCP office, the mental health clinician at the designated agency and the beneficiary

himself - work together to review and update his Care Plan to reflect his new medical condition.

The updated Plan of Care is documented in the web-based registry care management system and is directly accessible by the Enhanced Care Coordinator and PCP and all other members of the ICT on an as needed basis. The Plan of Care is shared with the beneficiary by mail or secure email, depending on their preference.

Case study # 2: Dually Eligible Beneficiary with Complex Needs who has Never Received Care Coordination

A 65 year old female lives alone in her mobile home in a small rural town in Vermont. She has Chronic Obstructive Pulmonary Disease and arthritis, and lives on a meager fixed income. She currently takes 10 different medications (both prescribed and over-the-counter) and has been hospitalized for repeated bouts of pneumonia. As part of the assessment conducted by the Enhanced Care Coordinator (her single point of contact), she has a Medication Therapy Management review of her prescription and over-the-counter medications. After a consultation with her primary care physician, she is able to reduce her prescription and over-the-counter medications to 5. In addition, her PCP gives her a pneumonia vaccine, a seasonal flu shot, a lesson in good hand washing techniques, and instructions on increasing her activity level. The information from the assessment also determines that she is eligible for both food and fuel assistance so she no longer has to choose between purchasing medications or buying food or fuel.

The Care Plan goals are to reduce stress and increase exercise, and to access food and fuel benefits to reduce stress and increase quality of life. Her Enhanced Care Coordinator works with her PCP-affiliated Blueprint Community Health Team to provide her with educational information about exercise classes, as outlined in the Stanford Model of Chronic Disease Self-Management program. In addition, her Enhanced Care Coordinator helps her locate and enroll in a women's only exercise program in her local community. The Enhanced Care Coordinator also assists her through the application and approval process for both food and fuel assistance.

During her routine annual reassessment, the Enhanced Care Coordinator learns that the woman is depressed due to the recent loss of two of her siblings. The Enhanced Care Coordinator works with the beneficiary to schedule several sessions of grief counseling and helps her arrange transportation to these appointments. The Enhanced Care Coordinator also helps the beneficiary access 2 days a week of Adult Day Services in her town's Adult Day Center to assist the beneficiary with social isolation. She also gets re-qualified for both food and fuel assistance. The Enhanced Care Coordinator also assist her to understand how to access Medicaid transportation benefits which she can use to obtain transportation back and forth to her appointments for mental health counseling.

The Plan of Care is documented in the web-based registry care management system and is directly accessible by the Enhanced Care Coordinator and PCP. The Plan of Care is shared with all other members of the individual's care team by secure email and with the beneficiary by mail or secure email, depending on their preference.

Case study # 3: Dually Eligible Beneficiary who only Needs PCP Support

A 65 year old female is in good health and visits her primary care provider yearly for preventive care and routine tests. She recently collapsed from a bout of dizziness and was taken to the emergency room where she is diagnosed with hypertension, given a prescription, and discharged with instructions to

contact her Primary Care Physician. Her Primary Care Physician conducts an exam and notes that she is borderline obese. She states she has anxiety about her finances and uses food as a stress reliever. The PCP adjusts her new medication, explains hypertension and how to control it, schedules quarterly follow up visits, and refers her to the practice-affiliated Blueprint Community Health Team (CHT) behavioral health specialist for education and support on over-eating and ways to control stress.

(Because her needs are only medical in nature and are managed by her PCP, she does not need to undergo a more comprehensive needs assessment. However, if her situation changes and she chooses to access her chosen Enhanced Care Coordinator, the Coordinator will conduct the risk assessment to help determine her needs and inform her comprehensive Care Plan.)

The Care Plan she develops with the CHT staff includes the goal of controlling her hypertension through a reduction of salt intake and weight reduction by walking 30 minutes a day 5 days a week, which also may help her anxiety. It also includes a 15-minute weekly telephone check-in with the CHT behavioral health specialist regarding this action plan.

At the quarterly visit, her PCP finds that her hypertension seems to be better under control, and that she has lost 6 pounds. She also seems motivated to keep exercising and trying to reduce her salt intake. She does not feel that she needs additional help from the CHT behavioral health specialist, but does mention that she doesn't really have a good understanding of how much salt she should be eating daily, or how to measure and calculate her salt intake. Her PCP suggests she talk with the CHT nutritionists, and hey set up an appointment for the following week. Her PCP also reminds her that she can access her Enhanced Care Coordinator should she have more complex health needs in the future.

The Plan of Care is documented in the Docsite system and is directly accessible by her PCP and the PCP-affiliated Community Health Team. Her Plan of Care is shared with the beneficiary by mail or secure email, depending on her preference.

WEB-BASED REGISTRY

Assessments, Care Plans and other relevant documentation regarding the needs and care of beneficiaries will be housed in Covisint DocSite™. DocSite is a web-based central registry used by the Blueprint Advanced Primary Care Practices for care planning, decision support and community care team coordination and collaboration by providing real-time access to electronic data and information. An essential advantage of the registry is that it can support coordinated health services across independent practices and organizations that may each have their own EMR or tracking system.

As such, DocSite is the perfect tool for use by all DVHA providers providing care and care coordination for beneficiaries enrolled in the Dual Eligibles Demonstration. The registry will be the tool used to share beneficiaries' assessments and Individual Care Plans among Interdisciplinary Team Members, and update the Plans as needed.

The registry will be made accessible to team members directly tied to their role in the care planning process for individuals. All team members who have access will be responsible for updating the information based on their interactions with the beneficiary. When updates are made to a case file, all other members of the care team are alerted electronically through the Docsite system. As such, the

registry will integrate assessments, documentation of case management, care planning, input from the interdisciplinary team, and support for transitions in care settings.

In addition, *Provide Link* is a new linked Covisint product that allows for secure fax communication and workflow automation between registry users and non-registry users. The web-based registry/ care management system can be accessed by ICT members via the internet or via a Virtual Private Network connection between their providers' practice or organization and the statewide health information network being developed by Vermont Information Technology Leaders (VITL) under contract with the State of Vermont.

Access to DocSite is password protected, and DocSite is fully compliant with HIPAA data security standards other federal and state IT requirements. The Enhanced Care Coordinator, with the beneficiary, will be responsible for identifying individuals who can have access to their DocSite registry information; this information will be documented in the beneficiary's Care Plan. The Enhanced Care Coordinator will be responsible for notifying the DocSite liaison if access needs to be changed due to altered ICT membership or other provider involvement.